Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BOB HOLLANDER, DC
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2207-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY CLAIM IN FULL FOR SERVICES RENDERED EVEN AFTER RECONSIDERATION HAS BEEN SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has not shown how or why it believes it is entitled to an additional $150.00."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2010	99456 W5 WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 03, 2011 with $500.00 payment.
   - CAC-B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - 907-ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSEABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated January 03, 2011 with $150.00 payment.
   - CAC-B22 THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - 907-ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSEABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated January 07, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Has the Designated Doctor Examination (DDE) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement under 28 Texas Administrative Code §134.204?

Findings

1. The respondent submitted EOB dated January 03, 2011 with denials CAC-B22 and 907 that reflect diagnoses/condition compensability and relatedness issues. Upon reconsideration, these denial reasons were not maintained as indicated on the January 07, 2011 EOB. MDFR will proceed with audit per applicable fee guidelines.
2. The provider billed the amount of $800.00 for CPT code 99456-W5-WP for DDE for Maximum Medical Improvement/Impairment Rating (MMI/IR) as a Designated Doctor (DD). Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on spinal region is $150.00. Per 28 Texas Administrative Code §134.204(j)(4)(D)(v), the MAR for an IR using non-musculoskeletal DRE method is $150.00.
3. Review of the documentation supports that MMI was assigned and two body areas were rated. DRE method IR was used on spinal region which is one musculoskeletal area including thoracic and lumbar per 28 Texas Administrative Code §134.204(4)(C)(i)(I). Also, a non-musculoskeletal condition DRE method IR was used for rib fracture. Carrier has appropriately reimbursed the MAR for these services in the amount of $650.00. There are no other areas rated. The requestor has not shown that additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 06, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.